Applicant Name: _____ FEIN: _____

Appendix A
State of New Jersey
Department of Banking and Insurance
Checklist and Certification
Multiple Employer Welfare Arrangement (MEWA) Health Plans
Filing Made Pursuant to P.L., 2001, c.352

Plan Name: _____

ERISA Filing Identification: _____

List of Forms Submitted (Identify each as contract, insert pages, rider or amendment, summary plan description, application, enrollment form or other (please identify)).

_____

_____

_____

_____

_____

			YES	NO
1.		Do the forms contain any provision, statements or questions that pertain to race, creed, color, national origin, ancestry or sexual orientation?		
2.		Are the forms in final printed format?		
3.		Do the forms contain unique identifying form numbers at the lower left corner of the first page?		
4.		Have person covered under the plans been issued information identifying the benefits the plans do not provide as required by NJSA 34:11A-14? If yes, attach a copy of the most recent list. If no, explain why below.		
5.		Do the forms comply with the readability requirements set for at NJSA 17B:17-21a?		
6.		Do the forms comply with the regulation on domestic violence set forth at NJAC 11:4-42.5(a)?		
7.		Do the forms comply with the requirements of Discontinuance and Replacement set forth at NJAC 11:2-13?		
8.		Do the forms contain a Coordination of Benefits provision consistent with the requirements of NJAC 11:4-28?		
9.		Do the plans contain definitions of the following terms which are at least as favorable to consumers as those contained in Appendix Exhibit A of NJAC 11:21?		
	a.	Ambulatory Surgical Center		
	b.	Birthing Center		
	c.	Dependent		
	d.	Diagnostic Services		
	e.	Emergency		
	f.	Employee		
	g.	Experimental or Investigational		
	h.	Extended Care Center		

			YES	NO
	i.	Health Status-Related Factor		
	j.	Hospice		
	k.	Hospital		
	l.	Medically Necessary and Appropriate		
	m.	Nurse		
	n.	Pre-Approval (or similar term)		
	o.	Pre-Existing Condition		
	p.	Private Duty Nursing		
	q.	Reasonable and Customary (or similar term)		
	r.	Rehabilitation Center		
	s.	Skilled Nursing Care		
	t.	Special Care Unit		
	u.	Total Disability or Totally Disabled		
	v.	Urgent Care		
10.		Do the plans contain provisions as identified below which are at least as favorable to consumers as those contained in Appendix Exhibit A of NJAC 11:21?		
	a.	Incontestability		
	b.	Payment of Premiums – Grace period		
	c.	Participation Requirements		
	d.	Term of Policy – Renewal Privilege – Termination		
	e.	Waiting Period		
	f.	Incapacitated Children		
	g.	If a network based plan, Continuation of Care		
	h.	Preexisting conditions and continuity of coverage		
11.		Do the forms provide benefits and coverage as identified below which are at least as favorable to consumers as those contained in Appendix Exhibit A of NJAC 11:21?		
	a.	Charges while hospitalized up to 30 days per calendar year (room and board) and ancillary charges.		
	b.	Emergency and Urgent Care Services		
	c.	Testing Charges – X-ray and laboratory prior to hospitalization		
	d.	Charges while confined in an Extended Care or Rehabilitation Facility up to 60 days per calendar year (in lieu of hospital confinement, 2 for 1 exchange for hospital days)		
	e.	Charges for home health care up to 60 days per calendar year (2 for 1 exchange for hospital days)		
	f.	Charges for hospice care up to 60 days per calendar year (2 for 1 exchange for hospital days)		
	g.	Food and food products for inherited metabolic diseases		
	h.	Practitioner charges for nonsurgical treatment, while hospitalized.		
	i.	Practitioner charges for surgery		
	j.	Second opinion charges		
	k.	Ambulatory surgical center charges		
	l.	Pregnancy as any other illness		
	m.	Birthing center charges		
	n.	Newborn child coverage		
	o.	Anesthesia		
	p.	Therapy services (as listed in Appendix Exhibit A)		
	q.	Preventive care ($100.00 per person; $300.00 per family per calendar year; first dollar coverage)		
	r.	Immunizations and lead screening		
	s.	Autologous bone marrow transplant and associated dose intensive		

			YES	NO
		chemotherapy, peripheral blood stem cell transplants.		
	t.	Prescription drugs – inpatient		
	u.	Insulin needles, syringes, glucose test strips, lancets		
	v.	Colostomy bags, belts and irrigators		

Explanation or clarification of response(s) to any item above:

I understand and agree that:

- To the best of my knowledge the forms described herein provide benefits and coverage at least as favorable to the consumer as that provided by Plan A as set forth at Appendix Exhibit A of N.J.A.C. 11:20.
- I understand that the Department of Banking and Insurance will rely on this certification in accepting this submission.
- If it is determined that the forms do not provide at least the minimum level of benefits and coverage of Plan A, I agree the plan will be amended to provide such benefits or coverage.
- I am aware of the penalties for submitting an improper certification or false submission.

_____
Signature of Responsible Officer

_____
Printed Name of Responsible Officer and Title

_____
Date